Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005836	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH FORCE OF INDIANA	334 N ENTERPRISE DR WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a state re-licensure survey. Survey Dates: 10/2/13 and 10/3/13 Facility #: 005836 Medicaid Vendor #: 200118810A Surveyor: Tonya Tucker, RN, PHNS Census: 94 Health Force of Indiana is in compliance with Indiana state rules for home health agencies 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN October 4, 2013	N 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE